Medical History Form – New Student Registration

Student Name: ____ Date of Birth: _________________________

1. Your Child
   a. Pregnancy & Birth
      Birth Weight: ___________ Full-Term Premature
      Describe any problems during pregnancy and/or birth:

   b. Developmental Milestones
      Age for Walking: _________ Talking: _________ Toileting: _________
      Describe eating habits: ____
      Describe sleeping habits: ____
      Describe difficulties during preschool years: ____
   c. Physical – Has/Does your child have any of the of the following? (Indicate Yes or No Below. If yes, explain in further comments.)

Hospitalizations
- Operations Yes No
- Illness Yes No

Allergies Yes No
- To: _______________________

Allergic Reactions Yes No
- Medications Yes No
- Foods Yes No
- Other _________ Yes No

Asthma Yes No
- On Medication Yes No

Bronchitis Yes No
Pneumonia Yes No
Finger/Thumb Sucking Yes No
Frequent Colds Yes No
Coordination Concerns Yes No
Bleeds Easily/Excessive Yes No
Dental Problems Yes No
Elimination
- Bed Wetting Yes No
- Constipation Yes No
- Diarrhea Yes No
- Daytime Incontinence Yes No
- Wears Pullups Yes No

Endocrine/Diabetes Yes No
Frequent Earaches Yes No
- Hearing Loss Yes No
- Ear Tubes Yes No

Emotional Concerns Yes No
Headaches Yes No

Joint Pain, Swelling, Limping Yes No
Muscular/Skeletal/Accident Prone Yes No
Frequent Sore Throats Yes No
Skin Problems/Concerns Yes No
Speech Problems/Concerns Yes No
Seizures Yes No
- Medications Yes No

Vision
- Problems/Concerns Yes No
- Sees an Eye Doctor Yes No
- Wears Glasses/Contacts Yes No

Worms/Parasites Yes No
Ever Passed Out/Unconscious Yes No
Prone to Nosebleeds Yes No
Tires Easily Yes No
Developmental Disabilities Yes No
Takes Medication Daily Yes No
- Medication Name _________________________

Further Comments:

d. Inner Self

Excessive Shyness	Yes	No
Temper Tantrums	Yes	No
Persistent Crying	Yes	No
Nail Biting	Yes	No
Social with Peers	Yes	No

2. Your Family

a. Family Members

Relationship	Birthdate	Name
Mother	XXXXXXX	____
Father	XXXXXXX	____
____________	_________	____
____________	_________	____
____________	_________	____
____________	_________	____
____________	_________	____
____________	_________	____
____________	_________	____
____________	_________	____

b. Medical History (Indicate Yes or No if immediate family members have history, as listed below)

Sudden Cardiac Death	Yes	No	Heart Disease	Yes	No
Allergies	Yes	No	High Blood Pressure	Yes	No
Asthma	Yes	No	Development Disability	Yes	No
Bleeding Disorders	Yes	No	Mental Health Illness	Yes	No
Vision Disorder	Yes	No	Lead Poisoning	Yes	No
Cancer	Yes	No	Seizures	Yes	No
Hearing Disorder	Yes	No	Tuberculosis	Yes	No
Diabetes	Yes	No	Kidney Disease	Yes	No
Drug/Alcohol Addiction	Yes	No			

Please note the relative for any Yes, above: ____

Further Comments/Information

Parent Signature: ____ Date: ____________________________